

DOCUMENT RESUME

ED 193 862

EC 130 837

AUTHOR Allin, Robert E., Jr.; And Others
TITLE Intensive Home-Based Treatment Interventions with Mentally Retarded/Emotionally Disturbed Individuals and Their Families.
PUB DATE Mar 80
NOTE 27p.; Paper presented at the Southeastern Psychological Association (Washington, DC, March, 1980).
EDRS PRICE MF01/PC02 Plus Postage.
DESCRIPTORS *Behavior Modification: Children; Delivery Systems; *Emotional Disturbances: Family (Sociological Unit); *Home Instruction; *Home Visits; *Mental Retardation; Models: Parent Child Relationship; Program Descriptions; Program Evaluation; *Therapy

ABSTRACT

A 2 year project to research, design, implement, and evaluate a model of service to families or "acting families" with a mentally retarded child who presents abusive and/or disruptive behaviors at home is discussed. In the project a husband/wife therapist team spent 80 to 100 hours per family over a 3 month period to assess the problems and implement a treatment plan. Therapist involvement typically involved training individuals in the use of behavioral and/or communicative techniques. Information on retardation and realistic expectation levels was provided and psychodynamic issues at both the individual and family levels were addressed. Preliminary results of an evaluation indicated that the program has reduced problem behaviors, increased independence skills, and reduced parents' feelings of being overwhelmed. Among appendixes are a chart listing client data, profile summaries on clients, and graphs charting client progress during treatment. (Author/PHR)

* Reproductions supplied by EDRS are the best that can be made *
* from the original document. *

U.S. DEPARTMENT OF HEALTH,
EDUCATION & WELFARE
NATIONAL INSTITUTE OF
EDUCATION

THIS DOCUMENT HAS BEEN REPRODUCED EXACTLY AS RECEIVED FROM THE PERSON OR ORGANIZATION ORIGINATING IT. POINTS OF VIEW OR OPINIONS STATED DO NOT NECESSARILY REPRESENT OFFICIAL NATIONAL INSTITUTE OF EDUCATION POSITION OR POLICY.

INTENSIVE HOME-BASED TREATMENT INTERVENTIONS WITH
MENTALLY RETARDED/EMOTIONALLY DISTURBED INDIVIDUALS AND THEIR FAMILIES

Robert B. Allin Jr.,
Diana W. Allin
Chesterfield County Mental Health and Mental Retardation Services
and
A. J. Finch Jr.
Virginia Treatment Center for Children

Paper presented at the
Southeastern Psychological Association Meeting
Washington, D.C.
March, 1980

"PERMISSION TO REPRODUCE THIS
MATERIAL HAS BEEN GRANTED BY

Robert B. Allin Jr.
A. J. Finch Jr.

TO THE EDUCATIONAL RESOURCES
INFORMATION CENTER (ERIC)."

ED193862

EC 130837

A 2-year project set up to research, design, implement, and evaluate a unique model of service for a traditionally underserved population is briefly described. Subjects include families or "acting families" with a mentally retarded member who presents abusive and/or disruptive behaviors at home. A husband-wife therapist team spends 80 - 100 hours per family "in-vivo" over a 3 month period for the purposes of problem assessment and treatment plan implementation. Therapist involvement typically includes training significant individuals in the use of behavioral and/or communicative techniques which are tailored to meet special needs and situational demands. Information on retardation and realistic expectation levels is provided and psychodynamic issues at individual and family levels are given attention. While a final evaluation of the overall program is pending, preliminary findings are indicated in the areas of reducing the presenting problem behaviors, increasing independence skills, and reducing parent's overwhelmed feelings. Aspects and advantages of home-based treatment intervention are also discussed.

A. INTRODUCTION

Services provided for individuals who are labeled as mentally-retarded and emotionally disturbed (MR/ED) have been practically nonexistent. Too often these individuals have been denied the services available to other persons with developmental disabilities. Typically this population has fallen between the cracks and jurisdictional conflicts have been extensive among professionals. Mental Health professionals have contended that such persons can best be served by the mental retardation division, while mental retardation workers have asserted that the emotional problems of such persons are outside their realm of expertise. Consequently the individual classified MR/ED has been tossed between services or has received no services at all. Often, the lack of appropriate service results in increased problem behaviors, necessitating long-term institutionalization (in either an MR or ED facility) or, in some cases, prison confinement.

The trends toward deinstitutionalization and normalization, the paucity of professionals, and the increased demands for alternative modes of services have contributed to increased interest and attention being given to the area of parent involvement. Parents have not only been the target for therapeutic intervention themselves, but have also been therapeutic agents assuming the roles of educator or trainer (Hawkins, Peterson, Schweid, and Bijou, 1966; Heifetz, 1977; Watson and Bassinger, 1974). While Berger and Foster (1976) report therapeutic intervention with parents of retarded or delayed children to be either of a dynamic, informational, or behavioral orientation, Tymchuck (1975) supports the combined use of these approaches in dealing with their diverse situational demands. While the typical setting for therapeutic interventions has been in an office or clinic situation, a small body of research has indicated that the home or natural environment can provide an excellent and even superior setting in which to assess and implement various treatment modalities. (Cianci, 1947; Hansen, 1968; Kinney, et al, 1977; Wolfensberger, 1967).

The involvement of trained professionals to work in the natural environment with persons viewed as mentally retarded and emotionally disturbed would seem to be a potentially effective form of treatment intervention. Parents or other supportive figures could be trained in the use of behavioral, communicative, and other such skills that would enable them to cope with and change problem behaviors. Having the intervention take place in the natural environment would further seem to enhance the therapeutic effort in that needs can be more easily and accurately assessed, treatment modalities can be tailored to suit individual and environmental situations, therapeutic methods can be taught and implemented directly in the environment where problems occur, and therapists can be present to give feedback and alter the treatment plan if necessary.

The present investigation, entitled the Home Intervention Program (HIP), is designed to study the effects of having a husband-wife therapist team intensively enter the home environment: 1) to teach parents or significant others skills in managing problem behaviors, 2) to become for parents an informational resource on mental retardation, and 3) to deal with more psychodynamically oriented issues which may impede treatment success. The program thus follows Tymchuck's (1975) Parent Therapy Model in its potential to be behavioral, informational, and dynamic in its orientation to any particular case.

The Home Intervention Program is actually part of a two-year project set up to research, design, implement, and evaluate a potentially effective model of service. The program is supported by a two-year grant from the Virginia Department of Mental Health and Mental Retardation and the Chesterfield County Mental Health and Mental Retardation Services Board. Research and design phases of the project began in January 1979, and actual work with clients started in May 1979.

The Home Intervention Program will add to the research in terms of its eclectic approach orientation with parents, its emphasis on intensive "in-vivo" intervention,

and its planned emphasis on program evaluation. More importantly, HIP is specifically designed for a difficult population that has received little or no attention in the literature where programs designed specifically for mentally retarded/emotionally disturbed individuals were not apparent. The present program will help to fill this void in the literature while at the same time help to fill the gap in services for this population.

B. METHOD

Subjects include families with a mentally retarded member (the "client") who presents abusive and/or disruptive behaviors at home. Problem behaviors typically have overwhelmed family members to the point that they no longer feel able to cope and outside placement seems the only recourse. Subjects are selected by a selection committee on the basis of "crisis level," inavailability of other services, reasonable potential to benefit from "in-home" treatment, and the family's motivation to accept home intervention as help.

The therapist team is intensively involved with each family over a three month period. From 60 to 70 hours are spent "in-vivo" (in client homes, classrooms, work arena's, etc.) during the first month. The first week of this period is spent observing behaviors and interactions to determine the exact nature of the problems and to develop with the family an individualized treatment plan. Skills training begins during the second week and advances as appropriate throughout the program's duration. Parents or significant others may, for example, be taught behavior management skills, effective communication skills, or be made more aware of realistic levels of expectation. Staff may utilize training manuals, other reading materials, audio-visual aids, modeling, guided practice, and practice.

During the second month actual contact time in the natural environment is reduced to 16 - 20 hours or 4 - 5 hours per week. Skills training continues

but the general focus is on the continued use of learned skills with increasingly less therapist guidance. The emphasis is placed on the ability of parents or significant others to apply learned techniques to new problems or situations.

The final month entails a further reduction of therapist contact time to one 2 - 3 hour visit per week. Treatment during the final month has a similar focus to that of the second month with the added issues centering around termination.

The home intervention program incorporates evaluative procedures into its design rather than considering evaluation as an after thought. Program implementation follows the delicate course of providing effective services to clients while also attempting to adhere closely to the standards of empiricle investigation. Dependent measures are obtained from parents or significant others in the areas of knowledge of behavior modification principles, sensitivity to others, family interactions, and locus of control. Dependent measures pertaining to each client's level of developmental and adaptive functioning are also obtained, in addition to data recorded on specific target behaviors. Goal Attainment Scales are established and rated to evaluate progress toward or away from highly individualized treatment goals. All measures are obtained on a "pre" (prior to any treatment procedures), "post" (at the end of the first or intensive month), and follow-up (at the end of all treatment procedures) basis. Consumer satisfaction is also determined at the end of treatment procedures.

C. RESULTS AND DISCUSSION

Due to the nature of the porgram and its intensive involvement with each client and client-family the number of cases to date has been limited. A final evaluation of the overall program is pending continued data collection and involvement with additional subjects and, as originally planned, will be completed after two years of work. Preliminary results, however, may be presented in terms of

individual case data.

Preliminary results of interest at this time include the more "visible" forms of data such as behavioral graphs and goal attainment scales which can be exemplified on a case by case basis. Positive findings are indicated in the areas of reducing the presenting problem behaviors, increasing independence skills, and reducing parent's overwhelmed feelings.

For example, the graph represented in Figure 1 shows data recorded for one client's (Case 1, SP) somatic behavior, while data recorded for the same client's completion of daily chores is presented in Figure 2.

Figures 3 and 4 represent Goal Attainment Scales established for two other client families (Case 2, JS; Case 3/4, EL and WL), one of which involved mentally retarded twins, and the "pre," "post," and "follow-up" ratings made for each scale.

Finally, data obtained from "pre," "post," and "follow-up" ratings of a client on the AAMD Adaptive Behavior Scale are represented in Figures 5 and 6. It is interesting that improvement over time in areas of the AAMD scale such as responsibility and independent functioning correspond with improvement reflected in behavioral data recorded for that client's work attendance (FIG. 7) and ability to take responsibility for his own morning wake-up. (FIG. 8).

To date, work with clients has made evident to project staff the numerous advantages of the Home Intervention Program model. Many of these advantages stem from the fact that treatment interventions take place in the natural environment.

It is important to note that these very positive aspects of home-intervention seem to be part of a gradual process which moves through stages as staff involvement progresses over time. Having individual's who are total strangers enter the family system is initially uncomfortable for all concerned, and invariably produces somewhat

of a "halo-period" during which language and behaviors of family members are guarded and quite different from that shown in the later stages of the program.

In general, therapists' presence in the home when problems have occurred seems to have greatly facilitated treatment, enabling them to more clearly understand the nature of problem situations, to make suggestions for change, and to support the efforts of family members to deal with problem behaviors. The therapists also have been able to model appropriate responses and practice them repeatedly with family members.

Close interaction in the home environment also seems to establish a high level of trust between family members and staff. Parents have expressed relief at having the therapists see and experience "what they go through." Moreover, the therapists' informal participation in family activities and routines has opened up channels of communication. The male-female or husband-wife team approach seems to further enhance this aspect in that family members seem to identify with the similarly-sexed team member, enhancing the therapeutic process. For example, one overwhelmed father related important information to the male member of the therapist team after they had worked together at plowing the family's garden for spring planting. The father had been previously uninvolved in the program.

These preliminary findings suggest that the Home Intervention Program model has great potential; as our effective service capable of meeting the special needs and problems of individuals with mental retardation and emotional disturbance, and as a valuable contributor to the research community.

REFERENCES

- Berger, M. & Foster, M. Family-level interventions for retarded children:
A multivariate approach to issues and strategies. Multivariate
Experimental Clinical Research, 1976, 2, 1-21.
- Cianci, V. Home supervision of mental deficiants in New Jersey.
American Journal of Mental Deficiency, 1947, 51 519-524.
- Hansen, C.C. An extended home visit with conjoint family therapy.
Family Process, 1968, 7, 67-87.
- Hawkins, R.P., Peterson, R.F., Schweid, E. and Bijou, S.W. Behavior
Therapy in the home: Amelioration of problem parent-child relations
with the parent in a therapeutic role. Journal of Exceptional
Child Psychology, 1966, 4, 99-107.
- Heifetz, L.J. Professional preciousness and the evaluation of parent
training strategies. In P. Mittler (Ed.) Research to practice in
mental retardation, Vol. 1 Baltimore, Md.: University Press,
1977, Pp. 205-212.
- Heifetz, L.J. Behavioral training for parents of retarded children:
Alternative formats based on instructional manuals, American
Journal of Mental Deficiency, 1977a, 82, 194-203.
- Kinney, J.M., Madsen, B. Fleming, T. & Haapala, D. Homebuilders: Keeping
families together. Journal of Consulting and Clinical Psychology,
1977, 45, 667-673.
- Tymchuck, A. Training parent Therapists. Mental Retardation, 1975,
13, 19-22.

Watson, L.S. & Bassinger, J.F. Parent training technology: A potential service delivery system. Mental Retardation, 1974, 12, 3-10.

(Psy Ab. 5950-53)

Wolfensberger, W. Counseling the parents of retarded children. In A.A. Baumeister (ED.), Mental retardation: Appraisal, education, and rehabilitation. Chicago: Aldine, 1967.

Appendix I
HIP Client Data

Prospective cases →

	SP	JS	WL	EL	SD	MS	BM	MX	JP
AGE (years)	23	32	7	7	22	1.5	6	17	17
MR Level	Borderline	Moderate	Moderate	Severe	Borderline	Dev Del	Profound	Mild	Profound
Presenting Problem	Bizzare beh., suicidal threats, depression, irresponsibility.	Destructive abusive beh. low freq. Potential explosiveness	Behs. "disruptive" to family.		Threatening, disruptive in work place. Family tension, verbal battles, irresponsibility	Tantrums, disruptive behs.	Self-abusive behs.	Abusive, physically aggressive to others; hair-pulling, hitting uncontrollable in classroom.	Abusive physically aggressive toward others, self abusive
Living situation at time of referral	Inst.	Home	Home	Home	Home	Home	Home	Home	Inst.
Program involvement	CSP OC HIP	OC HIP	School HIP	School HIP	OC HIP	In. Stim. Babysitter HIP	School HIP		
# in family	4	3	5	5	4 (-F)	4	5		

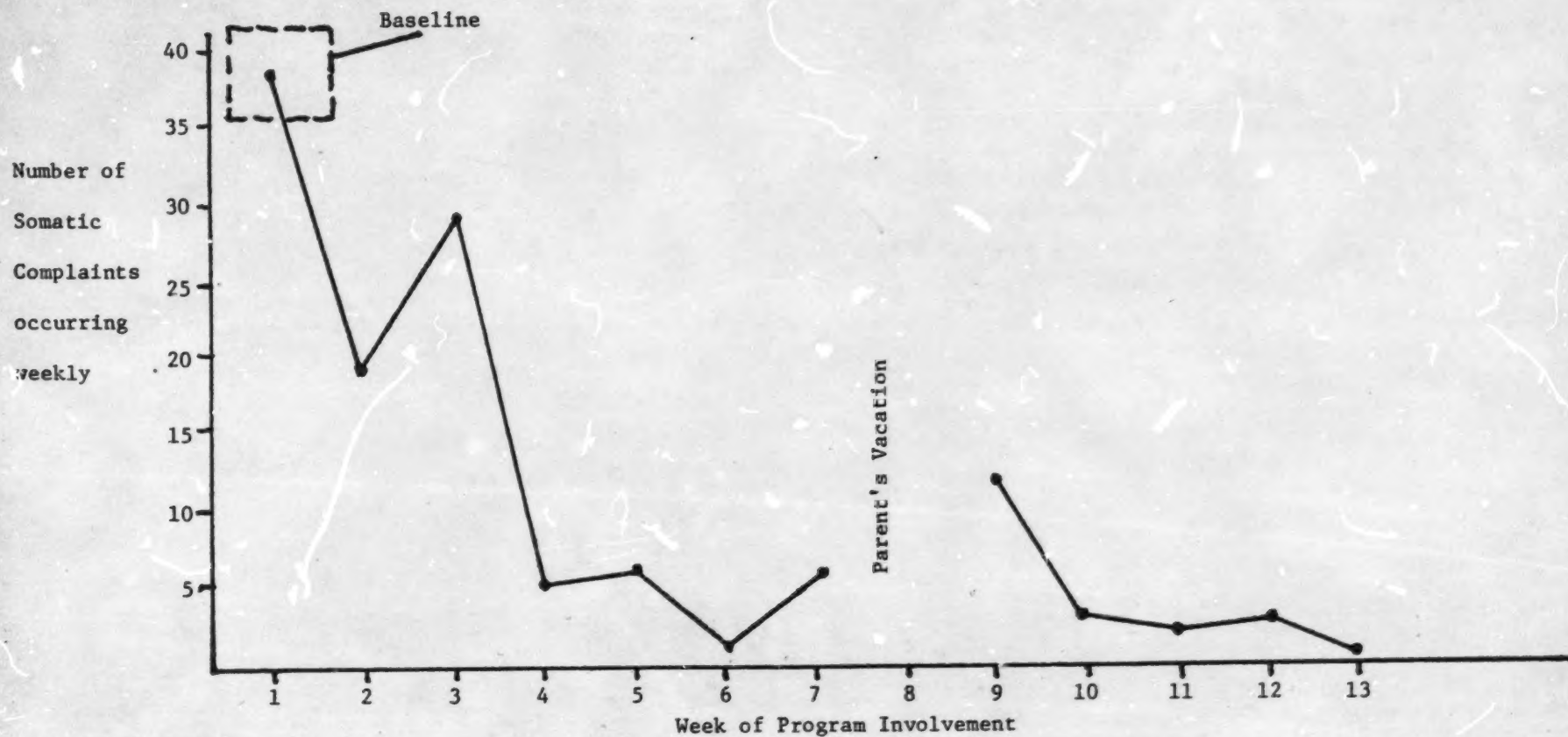


FIG.1 Number of Somatic complaints made per week of program involvement

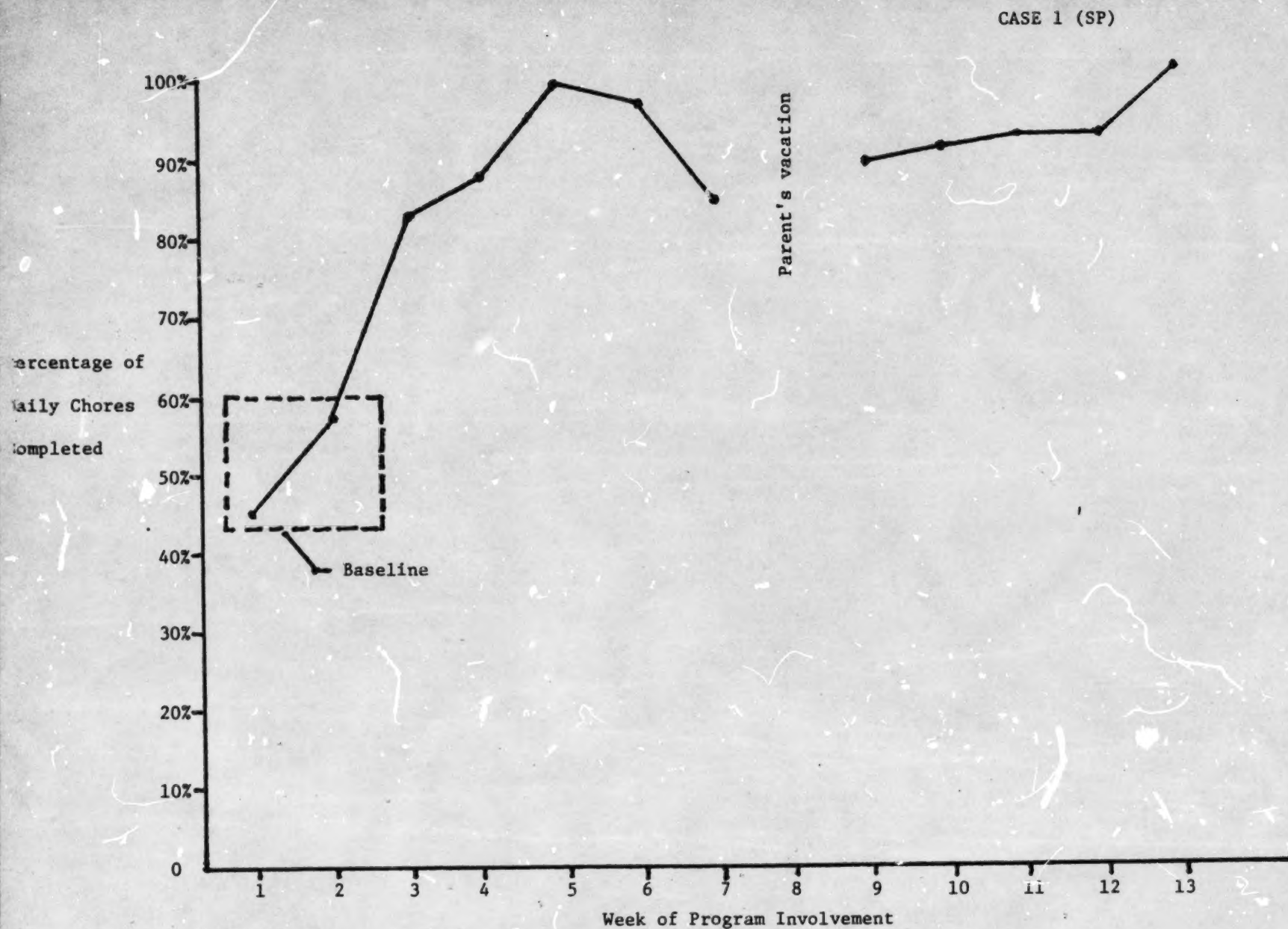


FIG.2 Percentage of daily chores completed per week of program involvement

FIGURE 3: GOAL ATTAINMENT SCALE

Case 2 (JS)

PRE ✓
 POST X
 FOLLOW-UP *

SCALE ATTAINMENT LEVELS					
	SCALE 1: Temper outbursts	SCALE 2: Independence (needs approval, needs help making decisions)	SCALE 3: Ability to identify and verbalize feel- ings to others	SCALE 4: Parents' overprotec- tiveness: assuming resp. for Joe's beh- making decisions for him, doing things for him	SCALE 5: Parents changing their behavior or routine to avoid problems with Joe (not confronting or criticizing, not leaving him alone at home.
a. most unfavorable treatment outcome (-2) thought likely	0 Joe has temper out- bursts which are high intensity and high frequency.	Joe does little of what he is capable of doing for him- self. He needs con- stant supervision and approval when doing those things. No motivation for independence	Joe cannot identify his own feelings and does not ver- bally express his feelings to others. He only acts out his feelings.	Parents always are overprotective of Joe. They never let him make independent decisions and always do many of the things that Joe is capable of doing for himself. (or is potentially capable of doing)	Parents always avoid problems w/Joe by changing their routine. They never confront or openly criticize Joe nor "expect" that he can change his be- havior.
b. less than expected success (-1) with treatment	2 When angry or frus- trated Joe throws or breaks objects, bites parents, throws objects at parents, outbursts are high intensity/ low frequency.	Joe takes some resp. for his own personal needs & can do some learned tasks on his own but needs frequent support, approval, and super- vision. Little motiv. for indep.	Joe has difficulty identifying his feeling and is re- luctant to discuss his feelings (esp. neg ones) with others. He acts out feelings more than verbalizes them.	Parents frequently overprotect Joe. They rarely let him make indep. decisions or take on personal responsibility.	Parents freq. avoid probs. w/Joe by chang- ing their routine. They seldom confront or openly criticize Joe or expect that he can change his behavior.
c. expected level of treatment (0) success	4 Joe has temper out- bursts that are of low intensity/low frequency. Extent & duration of outburst is minimal & he can say what more approp. ways he could have used.	Joe takes some resp. for his own personal needs & can do learned tasks on his own w/only occasional support, approval, & supervision. Some motiv for indep.	Joe can identify his basic feelings of love, hate, anger, hurt, content. He discusses his feelings when asked about them.	Parents are aware of when they are over- protective & actively seek to let Joe do more for himself. They hesitate at times to do so but feel it is in Joe's best interests.	Parents sometimes avoid probs. w/Joe by chang- ing their routine. * Parents feel fairly comfortable in confront- ing Joe directly and expect him to make changes.
d. more than expected success (+1) with treatment	6 When angry or frus- trated Joe can al- most always avoid inappropriate out- bursts and demon- strate approp. responses.	Joe takes most resp. for his own pers. need & does learned tasks w/ little support. He is strongly motivated to become more indep. & learn to do new things on his own.	Joe can identify his feelings & will discuss them when asked. He is able also to take some initiative in tell- ing others his feel- ings on his own.	Parents rarely over- protect Joe or assume resp. for that which Joe has capability of being himself. They expect & encour- age Joe to make de- cisions & take on responsibilities.	Parents rarely change their routine to avoid probs. w/Joe. They expect Joe to make changes & understand their needs more. They are able to leave him home alone whenever necessary. They feel comfortable in confront- ing him.
e. best anticipated success (+2) with treatment	8 Joe can tell others when he is angry/ frustrated and avoid outbursts by employing approp. coping behs.	Joe does all of what he is capable of doing for himself and needs very little support. He typically does learned chores tasks entirely on his own & can make some indep. decisions	Joe discusses posi- & neg feelings freely w/others. He clearly under- stands & can iden- tify his own feelings	Parents do not over- protect Joe. They in- stead assume the expecting, encourag- ing, and giving support to him in regards to his personal resp.	Parents never avoid probs. w/Joe by chang- ing their routine or making inappropriate concessions. They feel comfortable about & actively confront Joe when necessary.

FIGURE 4:

GOAL ATTAINMENT SCALE

CASE 3/4 (EL, WL)

PRE ✓
POST X
FOLLOW-UP *

SCALE ATTAINMENT LEVELS	SCALE 1: Communication	SCALE 2: Independence Self-help skills	SCALE 3: Behaviors which are considered problems by the parents: wondering out of the yard coming out of room at night going through refrig and cabinets	SCALE 4: Parents - clear Limit setting and consistency	SCALE 5: Parent's overwhelmed feelings
a. most unfavorable treatment outcome (-2) thought likely 1	0 E & W make no sounds or signs to express their needs.	Eddie and Wade refuse to do almost any self help skills independently.	Twins exhibit be- havior problems all of the time.	Unknowningly Parents reinforce negative behaviors and ex- tinguish positive be- haviors thru their inconsistency and unclear limit setting.	Parents are so over- whelmed that they feel that the only way for them to survive is for the twins to be removed from the home.
b. less than expected success (-1) with treatment 3	2 Neither Eddie or Wade make any sounds to express a need. They do use some signs.	Twins do very few self help skills and then only with constant supervision	Twins frequently exhibit problem behaviors.	Parents are aware of behavioral princi- ples: but are unable to be consistent and set clear limits	Parents feel over- whelmed and helpless in dealing with the twins.
c. expected level of treatment (0) success 5	4 Eddie and Wade will make a sound re- sembling the app- word and a sign by modeling to get needs met.	E & W do some self-help skills independently or with minimal supervision.	Twins occasionally exhibit problem behaviors.	Parents will be able to identify problems and set limits most of the time. They will be able to con- sistency reinforce behaviors some of the time.	Parents are gen- erally able to deal with the twins in a more objective manner and able to deal with own feel- ings of being over- whelmed.
d. more than expected success (+1) with treatment 7	6 E & W will make some sounds and signs independen- ly, some sounds & signs they will imitate to get needs met.	E & W will complete a self help skill independently once prompted verbally.	Twins seldom ex- hibit problem be- haviors.	Parents will be able to identify problems & set limits all of the time. They will be able to be able to consistently re- inforce behaviors most of the time.	Parents are able to deal with twins objectively and accept the decision they must make about them.
e. best anticipated success (+2) with treatment 9	8 Eddie and Wade will be independently saying words and signing to have needs met.	Twins know what self help skills they need to do and do them independent- ly.	Twins never exhibit behavior problems	Parents will be able to foresee the dev- of a problem behavior and using the above mentioned behavioral techniques prevent it from becoming a problem.	Parents are able to deal objectively with the twins & feel comfortable with their decisions about them.

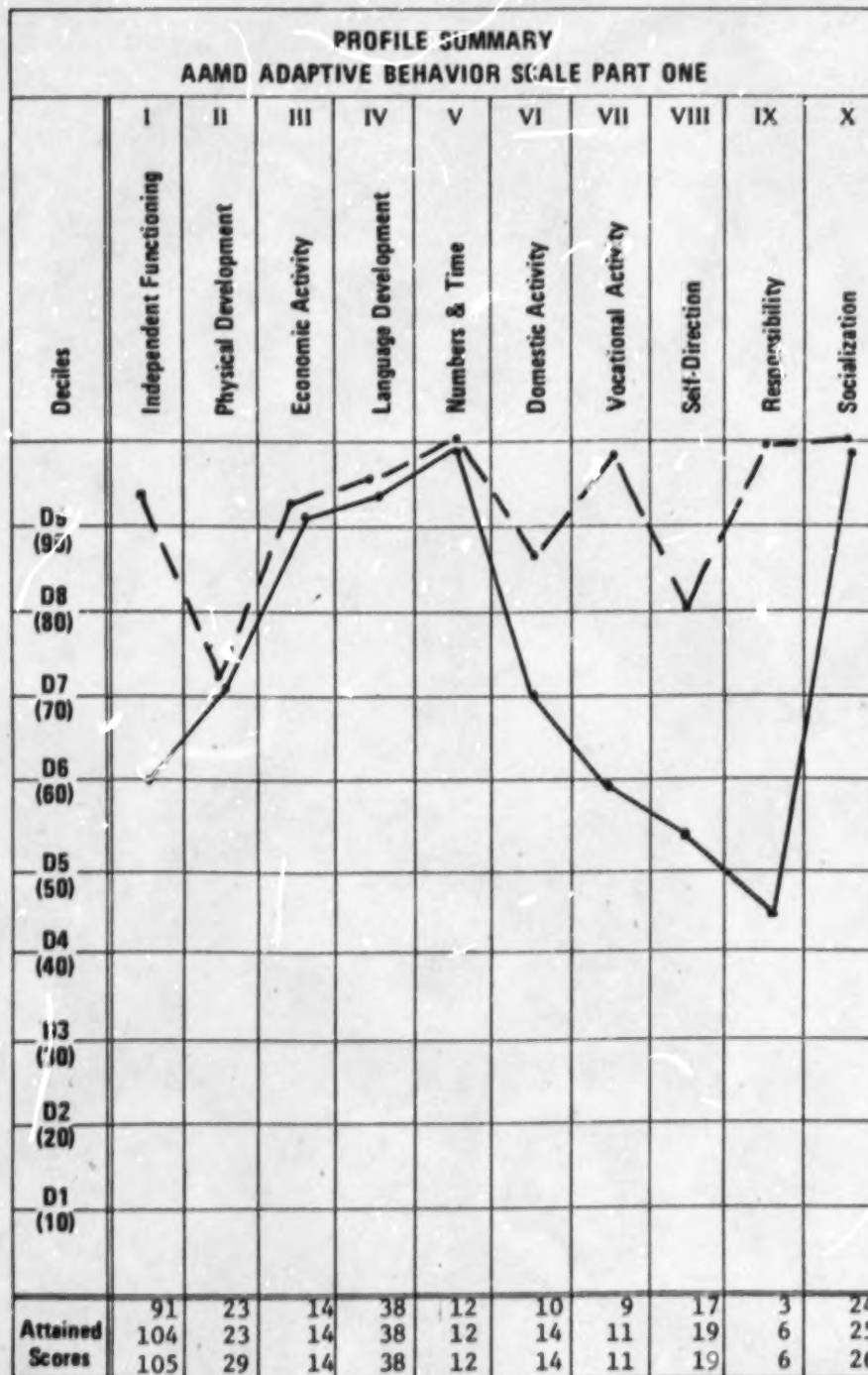
FIGURE 5

Identification Case 5 (SD)

Age 22

Sex M

Date of Administration _____



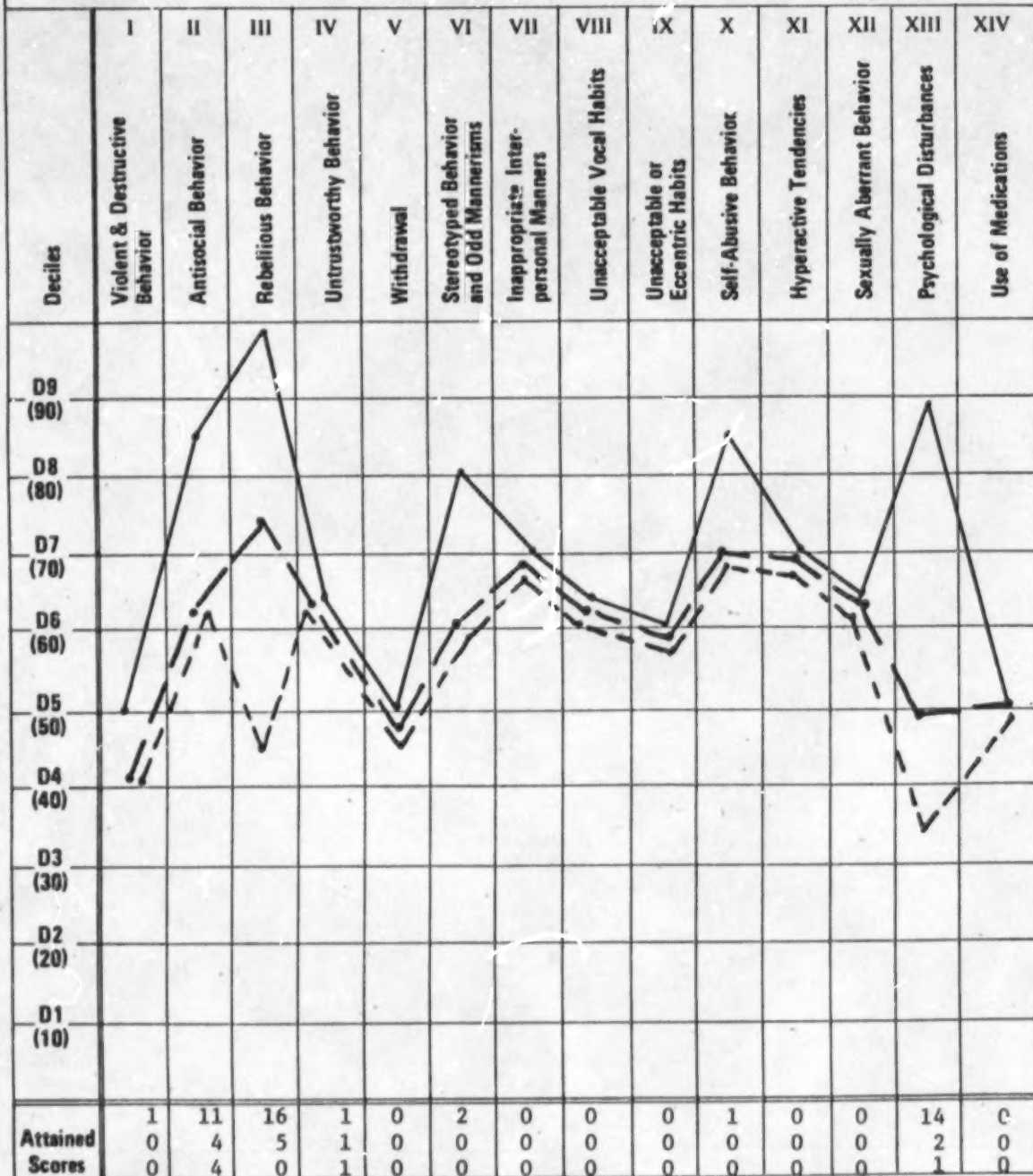
Identification Case 5 (SD)

Age 22

Sex M

Date of Administration _____

PROFILE SUMMARY
AAMD ADAPTIVE BEHAVIOR SCALE PART TWO



Pre _____
Post _____
Follow-up - - - - -

CASE 5 (SD)

(Data made available through Chesterfield)
(Occupational Center)

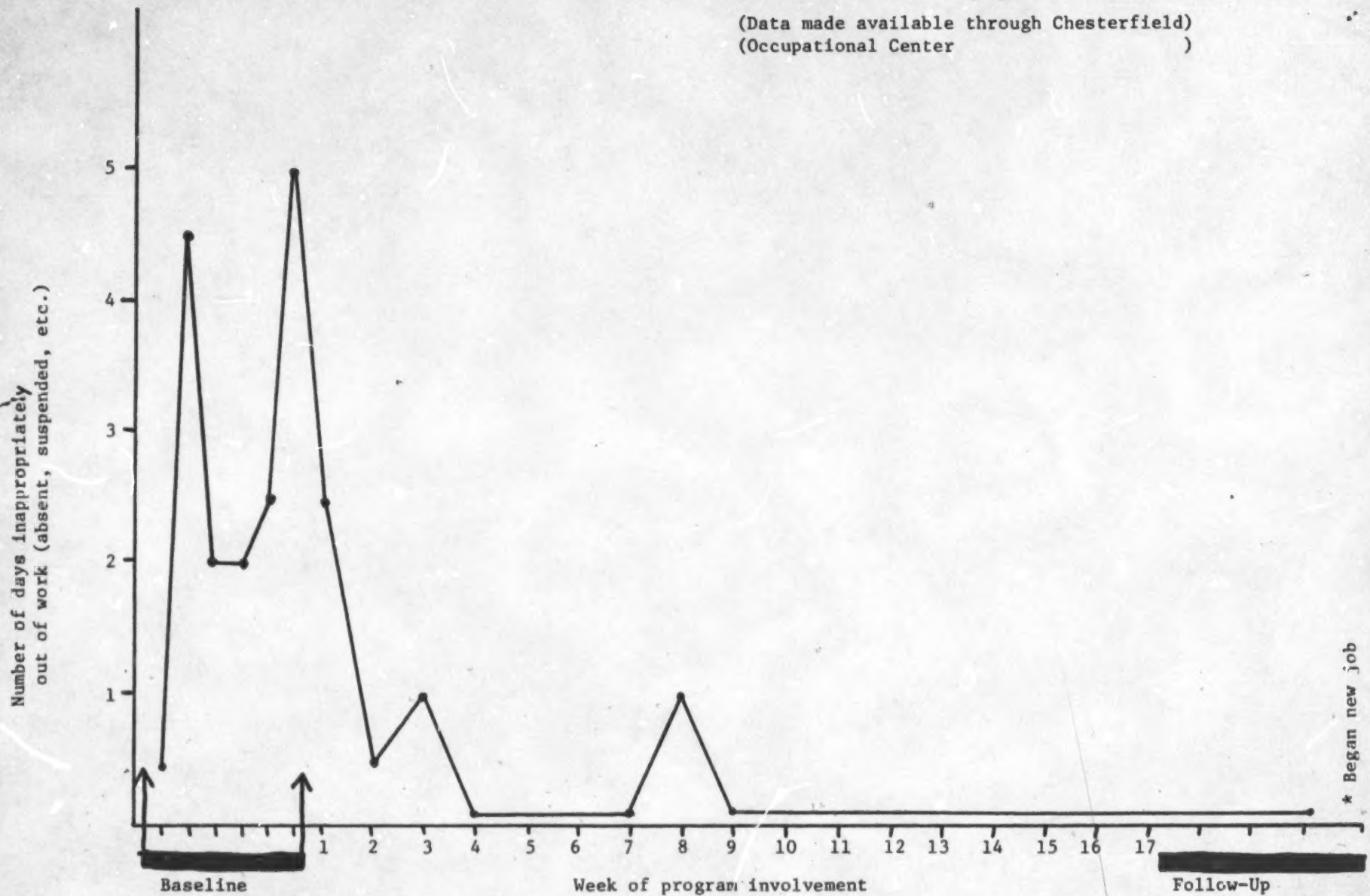


FIG.7 Days inappropriately "out of work" per week of program involvement

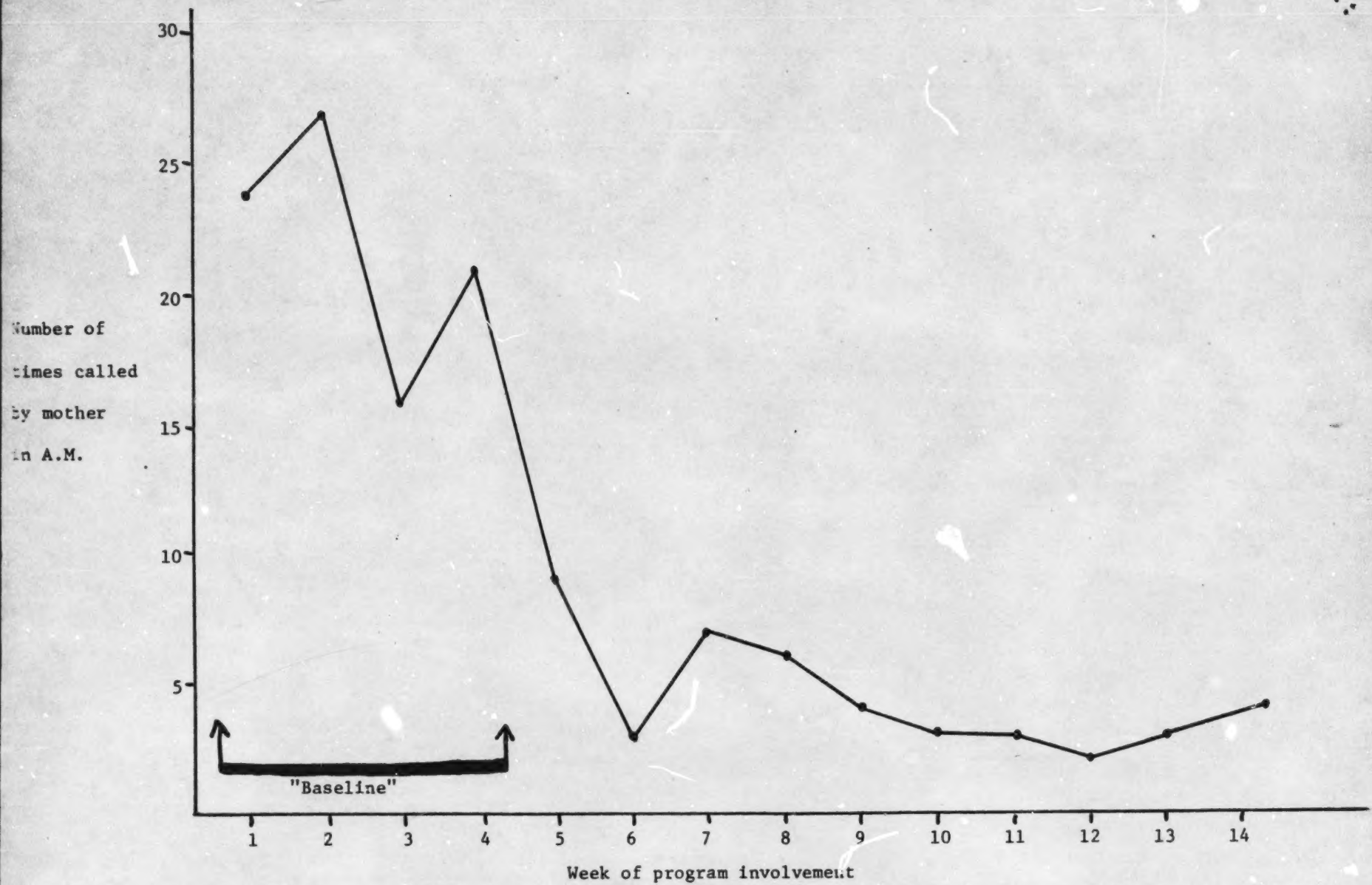


FIG. 8 Number of times called for A.M. wake-up by mother per week of program involvement